Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

MIDLAND TX 79703

Requestor Name and Address

TEXAS SURCIAL CENTER
5609 DEAUVILLE BLVD

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-1996-01

MFDR Date Received
FEBRUARY 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The ASC state mandated fee schedule for this code is $16,370.32."

Amount in Dispute: $6,846.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated March 7, 2012: "Reimbursement was issued according to the Medical Fee Guidelines. No additional reimbursement is needed."

Responses Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2011	ASC Services for CPT Code 24366-SG-RT	$6,846.90	$0.00
TOTAL		$6,846.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45- Charges exceed your contracted/legislated fee arrangement.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment

due.

- Z951-Additional allowance not recommended per fee schedule, usual and customary guidelines and-or provider's PPO contract.
- 42-Charges exceed our fee schedule or maximum allowable amount.

Issues

1. Does the submitted documentation support a contractual agreement issue exists in this dispute?
2. Is the requestor entitled to additional reimbursement for code 24366-SG-RT?

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. The "PPO ALLOW" amount on the submitted explanation of benefits denotes a "N/A" discount. The Division finds that documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services will be reviewed in accordance with applicable division rules and guidelines

2. CPT code 24366 is described as "Arthroplasty, radial head; with implant."

   Per ADDENDUM AA, CPT code 24366 is a device intensive procedure.

   Division rule at 28 TAC §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent."

   To determine the MAR for procedure code 24366 is a six step process:

   Step 1 gather factors:

   Addendum B hospital outpatient prospective payment amount for code 24366 CY 2011 is $8,596.24.

   The device dependent APC offset percentage found in the Addendum B for National Hospital OPPS for code 24366 for CY 2011 is 59%.

   The Medicare fully implemented ASC reimbursement for code 24366 CY 2011 is $7,068.23.

   The CMS City Wage Index for Midland, Texas is $0.9711.

   Step 2 determine the device portion:

   $8,596.24 multiplied by 59% = $5,071.78.

   Step 3 determine the geographically adjusted Medicare ASC reimbursement for code 24366:

   The Medicare fully implemented ASC reimbursement rate of $7,068.23 is divided by 2 = $3,534.11

   This number multiplied by the City Wage Index is $3,534.11 X 0.9711 = $3,431.97.

   Add these two together $3,534.11 + $3,431.97 = $6,966.08.

   Step 4 determine the service portion:

   Subtract the device portion from the geographically adjusted Medicare ASC reimbursement

   $6,966.08 minus $5,071.78 = $1,894.30.

   Step 5 multiply the service portion by the DWC payment adjustment factor of 235%

   $1,894.30 multiplied by 235% = $4,451.60

   Step 6 add the service and device portion together to determine MAR.

$5,071.78 add $4,451.60 = $9,523.38

The insurance carrier paid $9,523.42. As a result, additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		05/08/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.